Guide To Medicare Supplement Insurance

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California
Department of Insurance
Consumer Hotline: (800) 927-HELP
www.insurance.ca.gov
T.D.D. (800)482-4TDD

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Table of Contents

Table of Contents Continued

Introduction

This guide will answer some of your questions about Medicare Supplement insurance (also called Medigap insurance). It explains how Medicare Supplement insurance coordinates with Medicare, why you might consider buying it, what benefits it contains, and how to avoid becoming a victim of abusive sales tactics. This guide is not a legal document. The official Medicare Supplement provisions are contained in the relevant laws, regulations, and policy language.

Many of the answers in this guide will refer you to the Health Insurance Counseling and Advocacy Program (HICAP), which is the counseling and information program agency for Medicare beneficiaries and their families administered by the California Department of Aging. The HICAP program serves every county in California and is a free public service to answer your questions and to give you individual attention. You can reach your local HICAP by calling 800-434-0222. To avoid conflicts of interest, HICAP counselors are prohibited from being licensed to sell insurance or actively work for any insurance company or insurance agency. The counseling services are free. These counselors can explain any benefits you may already have and help you decide whether you should purchase Medicare Supplement insurance. If you decide to buy, they can help you select the appropriate benefits.

Do I Need Medicare Supplement Insurance?

Medicare Supplement policies help to pay the health care costs only if you have the Original Medicare Plan and have both Medicare Part A and Part B. Whether you need a Medicare Supplement policy is a decision only you can make.

You do not need to buy a Medicare Supplement policy if you are enrolled in the following Medicare Advantage (the new name for Medicare + Choice) plans.

- Medicare Managed Care Plan, or a
- Private Fee-for-Service Plan.

What Is Medicare?

Medicare is a Federally funded insurance program for eligible participants 65 or over, for eligible participants of any age who have been qualified as disabled, and for persons with End-Stage Renal Disease (ESRD).

There are two parts of Medicare: Part A (Hospital Insurance) and Part B (Medical Insurance). Under Medicare Part A, the Federal government will pay a portion of your expenses for inpatient hospitalization, skilled nursing facility care, hospice care services, home health care services, and for medically necessary blood transfusions. Medicare Part B covers your doctors' services, outpatient hospital care, and other medical services. To better understand your Medicare benefits and how to use them, read the *Medicare & You* handbook, which is available from your local Social Security office or by calling Medicare at 800-633-4227. You may also refer to the Medicare Web site at www.medicare.gov.

For each medical service Medicare covers, there is a portion that Medicare does not pay. Medicare Part A and Part B both have a deductible (the amount you must pay or must incur before Medicare will begin to pay). You must also pay the portion of the hospital or medical expenses for which you are responsible, commonly referred to as "coinsurance" or a "co-payment." The monthly premiums, deductibles and coinsurance for Medicare change each year. You can find out the current amount of these Medicare charges by contacting your local Social Security office.

Often people need medical services that Medicare does not cover. Such services as medical expenses incurred during foreign travel or outpatient prescription drugs are not covered by Medicare.

The Medicare handbook is reprinted each year to reflect any changes in deductibles, coinsurances, or benefits. Consult a current Medicare handbook for any changes to the Medicare plan.

Medicare Supplement Insurance Is Standardized

Congress passed legislation creating Federal standards for Medicare Supplement insurance policies that the states are required to adopt, with the exception of Massachusetts, Minnesota, and Wisconsin. Federally mandated standardization means that all Medicare Supplement insurance policies sold must contain a package of benefits conforming to one of the ten standard plans that are designated as Plan A through Plan J. An outline of the benefits in each of the ten standard plans is located starting on page 5.

As a result of standardization, comparison-shopping among different insurance carriers for Medicare Supplement insurance is relatively simple. For example, Plan C will contain the same benefits no matter which insurer sells it. Consumers can select policies based on premium cost and the special features or services offered by the Medicare Supplement insurance company.

Medicare Supplement Coverage Chart

Medicare Supplement insurance can be sold in only ten standardized plans. This chart shows the benefits included in each plan.

A	B	C	D	E	F	G	H	I	J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drug Benefit ($1,250 Limit)	Basic Drug Benefit ($1,250 Limit)	ExtendedDrug Benefit ($3,000 Limit)
				Preventive Care					Preventive Care

* Plan F & J also have high deductible options, some companies may offer these options.

Basic benefits are included in all plans. They include: Medicare Part A coinsurance plus coverage for 365 additional days during your lifetime after Medicare benefits end; Medicare Part B coinsurance; and the first three pints of blood or equal amounts of packed red blood cells per calendar year, unless this blood is replaced.

Standard Medicare Supplement Benefits

The basic benefits (also known as the "core benefits" or Plan A) are the minimum coverage you may buy. Plan A contains only the 3 core benefits listed below. Every other plan contains these three benefits as the "core" and then adds one or more additional benefits. Although Plan A is the least expensive policy, it may not be a good choice for low-income individuals who may not be able to afford the Medicare Part A hospital deductible when they are hospitalized.

(1) **Hospitalization**: Medicare Part A pays only a portion of the daily costs for hospitalizations. You must pay the coinsurance amounts for those days. This Medicare Supplement benefit pays the Part A coinsurance amount after the 60th day and an additional cost of 365 lifetime days.

(2) **Blood**: Medicare pays for all blood that is medically necessary except for the first three pints in each calendar year. This Medicare Supplement benefit pays for the first three pints of blood not paid for by Medicare, or equivalent quantities of packed red blood cells, as defined under federal regulations.

(3) **Medical Expenses**: Generally Medicare Part B pays for 80% of a predetermined amount (called the "Medicare approved" amount) for each procedure, supply, or service billed by your doctor or other provider that is not a hospital. This Medicare Supplement benefit pays the coinsurance (generally 20% of the "Medicare approved" amount) under Medicare Part B.

There are eight additional benefits that are combined with the basic benefits in various ways to make up the nine remaining Plans called Plan B through Plan J.

1. **The Part A Deductible:** The Medicare Part A deductible is the expense for which you are obligated to pay when you are admitted to a hospital as an inpatient. Medicare pays eligible benefits above that amount. (The Medicare Part A deductible amount may change yearly, so check the current handbook.) This Medicare Supplement benefit reimburses you

the deductible amount, no matter what the amount may be. This benefit is included in Plans B through J.

2. **Skilled Nursing Coinsurance:** Medicare Part A pays for the first 20 days of care in a skilled nursing facility following hospitalization, but requires you to pay a coinsurance beginning on the 21st day through the 100th day. This Medicare Supplement benefit pays the coinsurance amount beginning on the 21st day. This benefit is included in Plans C through J.

3. **Part B Deductible:** The Medicare Part B deductible is the amount you must pay each year for medical expenses (such as doctor fees) before Medicare begins paying. (The Part B deductible amount may change per year). This Medicare Supplement benefit reimburses you the deductible amount. This benefit is included in Plan C, Plan F, and Plan J.

4. **Part B Excess Charges:** Medicare Part B pays 80% of a predetermined amount (called the "Medicare approved" amount) for each procedure performed by your doctor or other medical care provider. If your doctor accepts Medicare "assignment," the provider may only bill you for the difference between the amount paid by Medicare and the amount approved by Medicare.

If your doctors do not accept Medicare assignment, they may bill you for the difference between the amount paid by Medicare and the amount they can legally charge you (called the "limiting charge.") If you have a Medicare Supplement Policy with the following:

Part B Excess Charges (100%) benefit, the policy will pay the full amount billed by your doctors or other providers who do not take Medicare assignment subject to the limiting charge. This benefit is included in Plan F, Plan I, and Plan J.

The Part B Excess Charge (80%) benefit, the policy will pay 80% of the amount you are billed by your doctors or other providers. This benefit is only in Plan G. Theoretically, you should save money on premium costs if you select the 80% benefit rather than the 100% benefit. Remember that this coinsurance amount is paid by the Medical Expenses part of

the Basic Benefits that are part of every Medicare Supplement insurance policy. All policies sold today must pay 50% coinsurance for outpatient mental health treatment services.

5. **Foreign Travel Emergency:** The original Medicare plan does not pay for medical care outside of the United States, but some Medicare managed care plans, private fee-for-service plans, and some Medicare Supplement plans do. This Medicare Supplement benefit will pay 80% of your expenses for most emergency medical care in a foreign country during the first 60 days of a trip abroad after you pay a $250 deductible. There is a lifetime maximum benefit, so check your current handbook for the dollar amount. This benefit is in Plan C through Plan J. Check your insurance coverage before you travel.

6. **At-Home Recovery**: Under the home health care benefit, Medicare pays for intermittent visits by a nurse or other skilled care provider in your home during recovery from an acute illness. Medicare does not pay for custodial care in your home such as homemaker services, (i.e. help with bathing, dressing, laundry, or shopping). This Medicare Supplement benefit pays per home visit. Check your handbook for current benefits for medically necessary custodial care while you are recovering from an illness, injury, or surgery. An insurance company may limit the number of visits to equal the number of Medicare home health care visits. This benefit is in Plan D, Plan G, Plan I, and Plan J.

7. **Basic Prescription Drug Benefit**: Until January 1, 2006 this benefit has an annual limit of $1,250. The extended prescription drug benefit has an annual limit of $3,000. Medicare does not generally pay for outpatient prescription drugs. Each of these Medicare Supplement benefits pays 50% of the cost for outpatient prescription drugs to a maximum of $1,250 or $3,000 per year depending on the plan you purchase. The basic drug benefit is in Plan H and Plan I. The extended drug benefit is in Plan J only. Starting January 1, 2006 plans H, I, and J may be sold without the prescription drug benefit.

8. **Preventive Care**: Medicare pays for some testing for diagnostic purposes. This Medicare Supplement benefit pays up to $120 per year for certain tests done for screening purposes, routine physical exams, patient education, and other medically appropriate tests

or preventive measures not covered by Medicare. This benefit is included in Plan E and Plan J.

Who Pays First If You Have Other Health Insurance?

If you have a question about who should pay, or who should pay first, check your insurance policy or coverage. It may include a coordination of benefits clause. You may call your insurance company or the Medicare Coordination of Benefits Contractor at 800-999-1118.

Open Enrollment for Purchasing a Medicare Policy

If you are 65 years old or older, you may buy any Medicare Supplement insurance policy, regardless of the condition of your health, during the "open enrollment" period. The open enrollment period lasts for six months after you first become eligible for Medicare Part B. Effective September 27, 2000, Medicare eligible disabled individuals under the age of 65 who do not have End-Stage Renal Disease now have the right to a six month open enrollment period beginning with their entitlement to Medicare Part B to purchase selected standardized Plans A, B, C, F or a prescription drug Plan H, I, or J at the discretion of the insurer. When a Medicare beneficiary under the age of 65 turns 65, they will have a second six month open enrollment period to purchase a standardized supplement policy for plans A through J.

Once you have purchased a Medicare Supplement Policy, you will have an annual open enrollment commencing with your birthday and ending 30 days later. The policy must be of equal or lesser value in coverage to your existing plan.

"Open Enrollment" means that no insurer may deny you the right to purchase any of the ten standard plans because of any preexisting medical condition, claims experience, or receipt of medical care. If you have a preexisting medical condition (a condition for which you received medical advice or treatment during the six months before your insurance begins), open enrollment is an important advantage to you.

NOTE: Although you are guaranteed the right to purchase any Medicare Supplement insurance product during open enrollment, insurers are permitted to impose a waiting period of up to six months before paying you benefits related to any preexisting condition, unless you have had prior creditable coverage.

If an applicant has had a continuous period of creditable coverage of at least six months, the issuer cannot exclude benefits based on a preexisting condition. "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage within the past 63 days from the end of their prior coverage.

"Creditable coverage" means, with respect to an individual, that they were covered under any individual or group contract which provided medical, hospital and surgical coverage that was not designed to supplement other plans.

If you have a preexisting medical condition, ask your agent to check the outline of coverage on the policy you are considering buying for the length of the waiting period as some policies have shorter waiting periods or no waiting period.

What Is Medicare Select?

Medicare Select is a PPO variation of Medicare standardized plans A through J initiated by Congress in 1990 that set standards for Preferred Provider Organizations (PPOs). PPOs attempt to cut costs by offering you a discount if you use a doctor or other medical provider who is a member of the PPO network. The "network" is made up of various health care provider groups, which contract to provide specific services to consumers. You are not required to use the providers in the network when it is an emergency or not reasonable to obtain services through a network provider, but you receive an advantage if you do (the advantage generally is that the insurance company will pay a larger percentage of the cost). Medicare Select PPOs offer standardized Medicare Supplement coverage through a PPO system. If you try a Medicare Select PPO system and you do not like it, you may switch to an individual Medicare Supplement policy if your insurance company offers one.

Individual vs. Group Insurance

An individual Medicare Supplement policy is a contract between you and the insurance company. Its provisions have the maximum number of consumer protections required under California law, but it is sometimes more expensive than group insurance. The law requires that every individual policy must be either "guaranteed renewable" or "noncancelable".

Guaranteed Renewable means that you have the right to continue the same coverage with no change in the terms of your policy, so long as you continue to pay the premiums on time. However, the insurance company has the right to change the premium. Of course, there is no guarantee that the insurer will not go bankrupt. Individuals covered by a company withdrawing/exiting the Medicare Supplement market shall have the opportunity to renew under another company and retain the same benefits.

Noncancelable means that you have the right to continue the same coverage, with no change in policy terms and *no change* in premium rates, so long as you continue to pay premiums on time. Check your contract language to determine if you have either a noncancelable or guaranteed renewable policy. Although insurers are authorized to write both types, most or all insurers have chosen to offer guaranteed renewable policies.

Group Medicare Supplement insurance is a contract between the insurance company and a group master-policyholder such as an employer acting on behalf of its employees. The group master-policyholder can also be a sponsoring organization such as a trade or professional association like AARP, Retired Officers Association, or a labor union specialized plan. If you are covered under a group plan, you receive a certificate rather than a policy of insurance, and the group master-policyholder negotiates the terms of the insurance and has the option to terminate the policy or insurance carriers. Often, but not always, group insurance is less expensive than individual insurance.

If your Medicare Supplement insurance group replaces the policy or the insurer with a new one, the new group insurer will offer everyone in your group the new coverage without exclusions for any preexisting condition that would have been covered under the prior group policy. The premiums may be higher.

Consumer Protections Required in All Medicare Supplement Insurance

30-Day Free Look: Every applicant for Medicare Supplement insurance, both individual and group, has the right to return any policy or certificate for any reason within 30 days of receiving that policy. The insurance company is required to refund all premiums and any other fees that have been paid. Your 30-day free look begins when you receive the policy or certificate. If you buy a "field-issued" policy (a policy that the agent delivers to you on the same day you complete the application), your 30-day free look begins when you receive a notice in the mail from the insurer. Always document the date you received the policy and the date you return the policy to the insurance company or the agent. Many applicants use that 30 days to discuss the purchase with family, friends, or with a HICAP counselor.

Waiting Periods for Preexisting Medical Conditions: No Medicare Supplement insurance may require a waiting period longer than six months for coverage of a preexisting condition. If you replace one policy or certificate with another, and have satisfied the waiting period under the first one, the replacing insurance company may not impose a new waiting period for the same preexisting condition. You must be given credit for your prior coverage.

Suspension of Coverage During Medical Eligibility: If you become eligible to receive Medi-Cal benefits, you can ask to have your Medicare Supplement insurance suspended for up to two years. If you become ineligible for Medi-Cal during the two years, you can ask to have your insurance benefits reinstated and begin paying premiums again.

Outline of Coverage: Every Medicare Supplement insurer and agent is required to give you an outline of coverage at the time you are offered insurance to buy. The outline of coverage contains a chart of all ten standardized plans and a chart for each plan offered by the

insurance company. It will probably summarize the terms and features unique to that insurance company. You do not have to fill out an application in order to get the outline of coverage. Compare different outlines of coverage in private with family members, friends, or a HICAP counselor.

Premium Refund: Insurers are required to refund any unearned monthly premium you paid in advance and terminate coverage when requested by the insured.

What Should I Look for When Comparison Shopping?

Premium Rates: Since standardization, the most important difference between Medicare Supplement insurance products is the premium cost. Be careful! Lower premiums are not necessarily the best choice.

Rating Methodology:

Attained Age Rating policies use a pricing method which automatically increase the premium as you age. These policies are usually less expensive during the first year, but the premium will increase automatically as you enter new age brackets. These automatic increases may be combined with premium increases based on inflation and higher medical costs, resulting in exceptionally steep increases as you get older**.** You may be "priced out" and find it costly to go elsewhere at an advanced age**.** California law requires a notice on each policy or certificate disclosing any automatic premium increases based on age.

Issue Age Pricing is a pricing method based on your age when the policy is first issued. The premium may increase with inflation, but not because you enter an older age bracket. Policies using this method appear slightly more expensive initially, but premiums do not automatically increase and are more reasonable in an older age bracket.

Community-Rate policies, also called No-Age Rated policies, charge everyone the same rate, regardless of their age.

Insurance Policy / Health Maintenance Plan:

While your local HICAP office can provide in depth comparison between indemnity based (traditional fee-for-service insurance) and managed care Medicare Supplement plans, a few initial distinctions between insurance and managed care policies may assist you in

researching the Medicare Supplement policy that best suits your needs and budget. The hallmark of traditional fee-for-service insurance is choice. Most indemnity based policies give you the freedom to choose your doctor, specialist, or hospital with few if any limitations. Also, the options you have with an insurance company are seldom limited by geographic restrictions.

The intent of managed care products is to create less costly delivery of health care services while maintaining quality health care by specifying provider choice. With managed care products you must obtain health care services from designated providers in most cases. Also, you are often limited by geographic restrictions of the managed care network.

Should I Replace My Non-Standardized Policy with a Newer Standardized Policy?

Not necessarily. If you bought a Medicare Supplement policy before July 1992, it may contain better benefits or suit you better than one of the new standardized policies. It may be less expensive than the same coverage in a standardized policy. Consult your HICAP counselor if you are considering replacing your coverage.

One disadvantage of replacing an older policy is that many insurers will charge higher premiums or deny coverage to applicants who have preexisting conditions. If you are considering replacement, first ask your current insurance company if you may update your coverage without submitting a new application. If your company agrees, only the medical conditions listed as preexisting in your original policy will be considered as preexisting

conditions. Also, request that your premium be calculated based on your age when you purchased the original policy. If your company agrees, the premium may be higher than the one for your original policy, but it will be lower than the cost to a first-time buyer. Remember that you have the right to switch to another company with similar benefits each year for 30 days following your birthday.

Never cancel existing coverage until a replacement policy is in force, and you are certain you want to keep it.

What Are Limited Benefit Health Plans?

Limited Benefit Health Plans also called Supplemental Plans are not Medicare Supplement Plans. Limited Benefit Health Plans may include the following:

- **Dread Disease Policies** that cover medical expenses or pay for a specific disease, usually cancer or stroke. Since medical treatment for all diseases are covered by Medicare, this coverage is duplicative;

- **Hospital Indemnity Policies** that pay a certain number of dollars for each day you are hospitalized. As hospital stays become shorter, these benefits are used less and less. More importantly, since Medicare Part A covers inpatient hospitalization, these policies may duplicate Medicare.

- **Accident Policies** that often pay a benefit for the loss of a limb or other body parts as a result of an accident. Since Medicare covers any medical treatment, regardless of the cause, this coverage may be unnecessary.

If you already own one of these policies when you buy a Medicare Supplement policy, discuss with your HICAP counselor the need and usefulness of these policies.

Know Your Rights

In California, agents owe you a duty of honesty, good faith, and fair dealing. Agents are specifically prohibited from doing the following:

- Using high pressure tactics (selling insurance through threat or undue pressure).
- Twisting (inducing you to give up or replace an existing policy for a new one).

- Overloading (selling you more insurance than you need or want).

Agents are required to give you an outline of coverage during the first presentation of an insurance product. The outline must inform you that HICAP is available for insurance counseling free-of-charge and tell you how to reach your local HICAP office.

If you decide to fill out an application, the agent is prohibited from taking more than one month's premium with the application unless interim coverage is provided (i.e. the policy is "field-issued"). Field-issued means that the agent has the authority to issue the policy to you at the same time you fill out the application. That is the only time the agent may collect two month's premium with the application.

Buy a comprehensive Medicare Supplement policy that has the most benefits for the amount you can afford. Make sure to consider the following before purchasing insurance:

- Comparison shop!
- Call the California Department of Insurance to verify if the agent and the insurer are properly licensed.
- Decide what you need and want before you sit down with the agent.
- Do not be rushed into buying insurance.
- Set the place, the beginning, and the ending time of your meeting.

- Get a second opinion before you buy or replace insurance.
- Do not buy anything you did not intend to purchase or do not want.
- Do not replace an existing policy unless you can not afford it or the benefits no longer meet your needs.
- Do not pay cash.
- Do not be intimidated.
- If you feel unsure or uncomfortable **DON'T DO IT**!

Is It Illegal to Sell You a Medicare Supplement Policy If You Have Medicaid?

If you have Medicaid (Medi-Cal in California), it is illegal for an insurance company to sell you a Medicare Supplement policy except in the following situations:

- If Medicaid pays your Medicare Supplement premium, then you can buy any Medicare Supplement policy.
- If Medicaid pays your Medicare premium, your deductibles and coinsurance, then you can buy Medicare Supplement Plans H, I, or J.
- If Medicaid pays all or part of your Medicare Part B premium, then you can buy any Medicare Supplement policy.

Buying Insurance Through the Mail

Direct response insurance companies sell Medicare Supplement insurance through the mail, without using agents. Their advertising must mention the availability of the outline of coverage and the company must send it to you with the application, or within 14 days of your request. Before completing the application, take the outline to HICAP for comparison. In all other ways, direct response insurers must follow the same rules. Because direct response companies do not pay agents commissions, the premium costs for mail order insurance are often, but not always, lower.

Who to Contact in the Event of a Problem with an Agent or an Insurance Company

The California Department of Insurance (CDI) licenses private insurance companies and insurance agents. The CDI assists consumers in resolving complaints and disputes concerning premium rates, claims handling, and many other problems with agents or companies.
The Consumer Hotline 800-927-4357 is serviced by experienced professionals who will answer your questions, provide appropriate referrals (such as referrals to your local HICAP office), send you brochures and other information published by the CDI, or assist you in filing a complaint.

If your claim is not paid in a timely manner, call the insurance company first. If you are still dissatisfied, contact the California Department of Insurance's Consumer Hotline to file a formal complaint: at:

California Department of Insurance
Consumer Services Division
300 South Spring Street, South Tower
Los Angeles, CA 90013
(800) 927-HELP (4357)

It is important to note that the CDI only regulates Medicare Supplement policies underwritten by licensed insurance companies. The CDI does not have regulatory authority over Medicare Health Maintenance Organizations (HMOs) or Medicare Supplement plans that are underwritten by managed care plans. Medicare HMOs (for example, Secure Horizon or Kaiser Senior plans) fall within the jurisdiction of the Centers for Medicare and Medicaid Services (CMS), while Medicare Supplement plans (for example, Blue Cross or Blue Shield) underwritten by managed care plans are regulated by the Department of Managed Health Care (DMHC).

If you have a problem or want to register a complaint about a Medicare HMO, you have to complete the following steps:

1. Appeal directly to the health plan by calling their customer service department.
2. If the health plan does not find in your favor, the appeal is automatically forwarded to an independent organization, the Center for Health Dispute Resolution (CHDR) that works for Medicare, not the health plan.
3. CHDR reviews the health plan's denial and determines if it should be upheld or overturned.
4. If CHDR upholds the denial, then you would need to contact Centers for Medicare and Medicaid Services (CMS) at 800-633-4227 for further assistance.

If you have a problem with a Medicare Supplement plan underwritten by a managed care plan, then contact the Department of Managed Health Care (DMHC) at 888-466-2219 for further assistance.